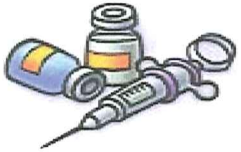
2010 Flu Clinic

Date:	Time:	Location:
October 26th	9:30 - 11:30	East Windsor Senior Center 125 Main St., Broad Brook
October 29th	9:00 - 11:00	East Windsor Town Hall 11 Rye St., Broad Brook
November 10th	2:00 - 3:30	East Windsor Town Hall Annex 25 School St., East Windsor

Insurance accepted will be: Medicare Part B, Aetna, Anthem, Connecticare and Healthnet. The fee for uninsured recipients is $35.00. Checks can be made out to VNHSC. If you have questions: (860) 872-9163.



Visiting Nurse &
HEALTH SERVICES
OF CONNECTICUT

FLU VACCINE INFORMATION

COMPONENTS OF 2010-2011 VACCINE

The influenza vaccine protects against the three most prevalent strains of flu expected this year. The 2010-2011 vaccine includes: A/California/7/2009 (H1N1), B/Brisbane/60/2008, and A/Perth/16/2009 (H3N2)

POSSIBLE SIDE EFFECTS

Most people have no side effects from the Flu shot. The most common reaction is soreness and or redness at the injection site for a day or two. Occasionally, persons may experience a fever or achiness for one or two days. As with any drug or vaccine, there is a slight possibility that an allergic reaction or even death could occur.

THE VACCINE CAN NOT CAUSE INFLUENZA. RESPIRATORY ILLNESS AFTER VACCINATION IS COINCIDENTAL AND UNRELATED TO THE VACCINE.

IMPORTANT

DO NOT TAKE THE SHOT IF:

- ✓ You have ever had a serious reaction to a flu shot.
- ✓ You have a severe allergy to eggs, chickens, chicken feathers or chicken dander.
- ✓ You have a moderate to severe acute illness.
- ✓ You have ever had Guillain Barre Syndrome.
- ✓ You have a known allergy to Thimerosal; a mercury derivative used as a preservative in Cosmetics and contact lens solutions.
- ✓ You have a known allergy to Latex.
- ✓ You have an unstable neurological disorder.

- ✸ Pregnant women should get this shot from their physician.

QUESTIONS:

If you have any questions about Influenza or Influenza Vaccine, ask now or call your physician or local Health Department.

REACTIONS:

If you become ill and visit a doctor, hospital or clinic in the four weeks after today's injection, please report this to:

Visiting Nurse & Health Services of Connecticut, Inc.
8 Keynote Drive, Vernon, CT 06066
860 872-9163

VISITING NURSE & HEALTH SERVICES OF CONNECTICUT, INC.
FLU CLINIC VACCINE FORM

_____ _____
Clinic Site Date of Immunization

Print
NAME: _____ _____
Last First Middle Phone

Print
ADDRESS: _____ _____
Street Town State Zip Code

☐ M ☐ F _____/_____/_____
(Gender) Date of Birth

SELECT PRIMARY INSURANCE:

☐ Medicare (Part B only) ☐ Cash ☐ Check
☐ Aetna
☐ Anthem Blue Cross (commercial only)
☐ ConnectiCare
☐ Health Net

Is this a Medicare Plan? **ID/Policy #** _____
☐ **Yes** ☐ **No**

I have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I have received a copy of the agency privacy policy.

It is requested that I remain in the building for 20 minutes. If I choose to leave for any reason, I will assume full responsibility for any reaction that may occur.

I authorize VNHSC to release any medical or other information necessary to process a claim.

If my insurance denies payment for any reason, I will be responsible for the $35.00 charge, payable upon receipt. If a co-pay applies, you will be billed appropriately.

X _____ _____
Signature of Recipient (or authorized person) (today's date)

Manufacturer and Lot # Site of Injection: ☐ R ☐ L (deltoid)

X _____ _____
Signature of nurse (today's date)